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A MAGAZINE FOR DENTISTS, DENTAL ASSISTANTS, AND DENTAL HYGIENISTS

ptember 1954, Vol. XIII, No. 9

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Cover artist, Edward Kasper

The Curve of Spee

by Frank H. McKevitt, D.D.S.

Contrary to accepted belief, Ferdinand Graf von Spee was not a dentist, but an embryologist of note. It was he who described the compound curves formed by the plane of occlusion of the natural human dentition, the anteroposterior curve of which takes an undulating course that dips buccolingually, thus adding a transverse curve to its morphologic structure. The function of these curves is definite as they maintain the occlusal surfaces of the teeth at right angles to the line of closure of the mandible. In simpler terms, one single tooth or combination of teeth cannot take the entire brunt of closing forces because of the evenly distributed stress normally applied during mastication.

The elementary movements of the mandible are many and varied. For purposes of description, they may be divided into categories. The first of these is the straight opening and closing movement; the second, the incising bite balancing position; third, the right and left balancing and working positions; and finally, combinations of these movements, which Doctor George Wood Clapp has adequately described in *Prosthetic Articulation.*

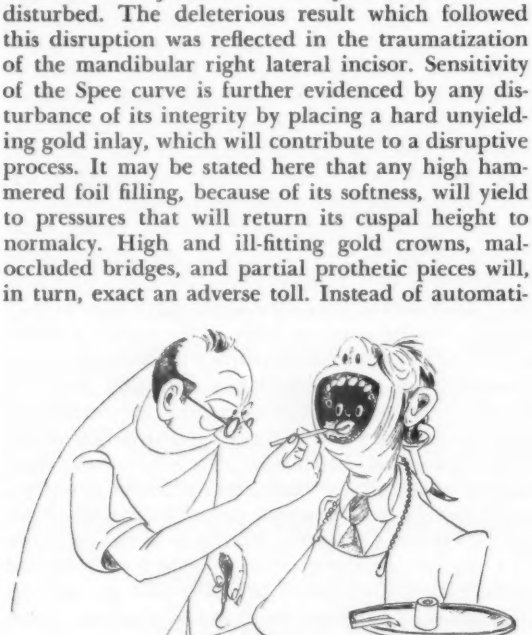
This paper will describe the functions of the teeth only as they pertain to contacts with the curve of Spee or the plane of occlusion, and more specifically, to deviations from the normal curves which have resulted from pathological processes that have destroyed the normal conditions. These deviations are conditions that have resulted in increases and decreases in the height of the interalveolar ridge space and which have diverted normal right and left movements of 60° in the horizontal plane to abnormal angles that require Gothic Arch tracings to record them on adaptable articulators. To quote Clapp, the functions of the teeth are as follows: "The incisors are intended to bite the food from the mass, the cuspids have a prehensile function and act also as guides of lateral motion in the anterior part of the jaw, (and) they serve further as shock absorbers in mastication. The bicuspids are the crackers and breakers of all hard and brittle foods, and the tearers and separators of fibers. The molars grind the fibers into shreds for further elaboration with the hydrochloric acid glands in the stomach." These functions are impaired when the curve of Spee is damaged.

The chewing forces normally applied are, on the average, about one hundred and fifty pounds. A variation on the plus side is

exemplified by the trapeze performer weighing one hundred and sixty pounds who steps from a platform with an adjusted mouthpiece between the teeth. His weight, plus the amplitude of the body swing as it launches through space, more than doubles the stress applied to the curve of Spee. Compare this potential pressure with the intermittent forces of closing, applied to full artificial dentures, which is said not to exceed thirty pounds at its maximum. In chewing it is implied that individual pressures vary in a plus and minus degree because of different tones of musculatures. The example set forth by the acrobat will serve to emphasize the force of maximum individual pressures against the maxillary Spee by the mandible.

One can take as a parallel, differing in degree only, the instance of biting down on a piece of buckshot when eating a prepared wild duck and note the uneven pressure applied and the resulting deleterious effect upon the involved teeth because of non-equilibration.

In normal working conditions, note for purposes of comparison the individual with a full compliment of thirty-two teeth from which the mandibular left third molar had been removed. The fine balance and adjustment of the Spee curve had been disturbed. The deleterious result which followed this disruption was reflected in the traumatization of the mandibular right lateral incisor. Sensitivity of the Spee curve is further evidenced by any disturbance of its integrity by placing a hard unyielding gold inlay, which will contribute to a disruptive process. It may be stated here that any high hammered foil filling, because of its softness, will yield to pressures that will return its cuspal height to normalcy. High and ill-fitting gold crowns, malocculded bridges, and partial prothetic pieces will, in turn, exact an adverse toll. Instead of automatically adjusting to opposing surfaces, they will break down the supporting tissues and traumatize the meniscuses with which the condyles articulate. The profession in general has a normal awareness of the insidious effects of staggered extractions upon the curve of Spee.



"Failure to Take Cognizance"

In England, in the early part of the century, when a mandibular or maxillary first molar was removed it was customary to sacrifice the remaining first molars in order to maintain equilibration. In these cases, lateral drifting and exfoliation of the teeth was implied and therefore anticipated. Present-day awareness of these phenomena is implied when deciduous embrasures are controlled with space-retaining appliances and permanent tooth embrasures are bridged with partial prosthetic pieces to conserve the integrity of the Spee curve. Failure to take cognizance of these phenomena leads to ultimate changes in the height of the interalveolar crestline space. Attention is attracted to these changes only when they have reached an advanced stage and normal conditions have been destroyed or almost so.

Following the completion of destructive processes, Bennett suggested "that a scientific method be found to restore the correct height of the bite and the correct plane of occlusion in edentulous cases as disease had destroyed the normal conditions." Bennett possessed remarkable powers of observation and diagnostic acumen. He lived at a time when dental roentgenograms were not in general use. He recognized pathological conditions and their effect upon the curve of Spee and the height of the interalveolar space, but could offer no method of recapturing the extant height of the space resulting from pathologic causes; nor could Gysi, who devised an adaptable articulator.

The problem is one to be solved at the chair, by the individual operator, whithersoever dispersed. Here a knowledge of normal conditions is essential for comparison with those of pathologic origin which deviate from the normal. Of these there are two; one, because of atrophic changes, increases the dimension of the space; other pathologic factors decreased it. A third non-pathologic factor consists of man-made defections at the chair.

Two Deviating Causes

The normal height of the interalveolar space is established by the eruption of the mandibular and maxillary first molars. The elevation of the plane of occlusion, or the curve of Spee, is established at the same time by the occlusal surfaces of the teeth and remains constant through life. Normal space heights vary from patient to patient and cannot be averaged. They are subject to two distinct de-

viating causes because of pathologic processes, the results of which are well defined and easily recognized in roentgenograms and on casts. A non-pathogenic factor, germane to this discussion, originates at the chair and the height of the space is increased. These separate causes of deviation from normal space heights will be described in the order named:

The first consists of atrophic changes, which cause the ridgecrests of the alveolar processes in the mandible and maxillae to draw away from the constant plane of occlusion, in opposite directions from it, thus increasing the height of the interalveolar space.

The second deviation from the normal can be attributed to five separate factors which cause the ridgecrests to approach the constant occlusal plane from opposite directions, and at times, to continue until stopped by the opposing ridges. They are:

1. Hypertrophies of the maxillary tuberosities
2. Abrasions of the occlusal surfaces of the teeth
3. Drifting teeth
4. Exfoliating teeth
5. Staggered extractions

Non-pathologic factors are caused by opening the space inadvertently at the chair by non-articulating prosthetic partial pieces, high crowns, high inlays, and re-basing or relining older dentures.

There are thirty or more causes of osteomalic diseases which affect the alveolar processes, directly or indirectly, and which contribute to the common factor, atrophy, which in one word describes the cause of increases in the length of the interalveolar space without affecting the constancy of the location of the occlusal plane.

Decreases in the Height of the Space

In contradistinction there are five separate factors which contribute to decreases in the height of the space.

Hypertrophied maxillary tuberosites occur in the molar areas and develop vertically toward the constant plane of occlusion and, at times, continue on to the superior border of the mandible. This tissue must be removed surgically, as it deprives the interalveolar space of sufficient room for artificial replacements.

Abrasions of the molar and bicuspid occlusal surfaces and the incisal edges of the incisor teeth, in cases of sclerotic bone, continue to their cervices without infringing the integrity of the alveolar processes that hold them. The incisal edges of the teeth in the mobile mandible abrade, and in turn are abraded, by the incisal edges of the opposing maxillary incisors in the fixed maxillae. The incisal edges of the mandibular teeth cross the constant occlusal plane and decrease the height of the interalveolar space.

Drifting teeth result from staggered extractions and are cited as a cause of decreasing the space. Intermittent pressures from the mandible force the tooth or teeth into embrasures left by adjacent extractions.

Exfoliating teeth result from disuse. When their antagonists have been lost, at times they extrude beyond the constant plane of occlusion to opposite ridgecrests. This action unbalances the articulation and decreases the height of the interalveolar space. Radical surgery is required to regain sufficient space for the replacement of artificial substitutes.

Staggered extractions keep the curve of Spee in uneasy balance, finally to wreck the dentition, for each tooth in the arch is, in itself, a keystone.

A third factor, non-pathogenic in origin, is induced by the indiscriminate relining and rebasing of old dentures and immediate dentures which are given supposedly permanent status by relining them. The extant height of the interalveolar space is thus increased beyond the normal limit and induces a temporomandibular arthrosis.

Pre-Extraction Casts

Pre-extraction casts to be used as controls are indicated. The extant height of the interalveolar space is increased following the installation of immediate dentures. When regeneration of the bone is concluded, replacements of the dentures becomes a hazardous enterprise when and if pre-extraction casts, for use as controls, are eliminated from the restorative plan.

In the edentulous state the restoration of the original morphological structure of the curve of

"So I said to Mabel: 'To heck with the payment on the new car this month—let's settle up with Doc first.'"

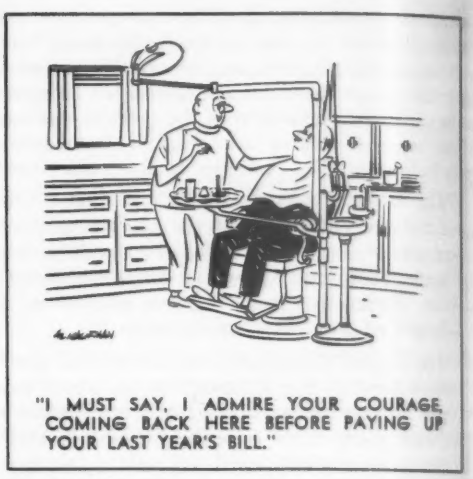
Spee is a physical impossibility. The elevation of the plane of occlusion, comprising the curve and the extant height of the interalveolar space, must be joined as an integrated unit.

The curved occlusal plane must be reduced to a flattened plane to which twenty-eight porcelain replacements are to be set. The leveled plane should facilitate their arrangement according to sound engineering principles.

The recapture of the arbitrary plane of occlusion and the extant height of the interalveolar space begins with a line drawn on the face with a tissue pencil. It extends from the inferior border of the auditory meatus to the ala of the nose. The chosen elevation of the plane on the maxillary bite rim is paralleled anteroposteriorly with the tracus ala line and thence laterally with an imaginary line drawn through the pupils of the eyes. The maxillary compound bite rim is then carefully gauged, equalized, and notched to receive its mandibular occlusal rim, which is designed to record the completed height of the measured interalveolar space.

The Importance of Accuracy . . .

The importance of accuracy in re-establishing the height of the arbitrary occlusal plane cannot be over-emphasized as careful workers utilize it to inscribe the Gothic Arch tracing. Any deviation from the correct elevation of the plane of occlusion will nullify its purpose and also that of the check bites, used in conjunction.

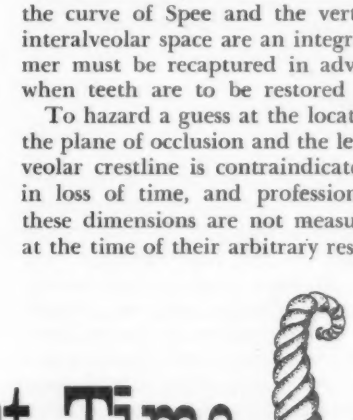


"I MUST SAY, I ADMIRE YOUR COURAGE, COMING BACK HERE BEFORE PAYING UP YOUR LAST YEAR'S BILL."

In conclusion, it can be stated unequivocally that the curve of Spee and the vertical height of the interalveolar space are an integrated unit. The former must be recaptured in advance of the latter, when teeth are to be restored artificially.

To hazard a guess at the location or elevation of the plane of occlusion and the length of the interalveolar crestline is contraindicated. It often results in loss of time, and professional prestige, when these dimensions are not measured in millimeters at the time of their arbitrary restoration.

At Harvest Time



Since nearly every dentist shares
A yen to go a-farming,
Wife and relatives may find
This urge somewhat alarming.

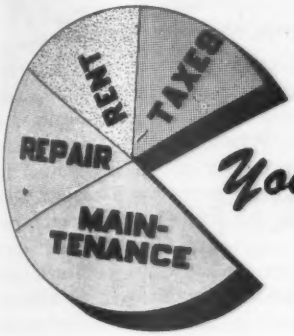
They know the yen is sired by
A glimpse of pasture land,
With rolling hills where cattle graze—
This one can understand.

No doubt the farm house, barns and such,
All more than passing fair,
Are ten to one supported by
A multimillionaire.

No lesser place has he in mind,
This gives his family pause;
They know he'll never, never own,
A place like this — because!

Ethel Willis Hewitt

Office Improvements:



You Can't Take Them With You.

by Harold J. Ashe

Dentists need to keep their critical faculties when entering into lease agreements for office space. Time was when most office leases were for straight cash rent, unqualified by other considerations.

Now, with a marked trend toward the suburbs and outlying shopping areas by professional men, an increasing number of dentists are leaving downtown buildings for ground floor structures. Sometimes a small office building will be occupied solely by a dentist; in other cases, a dentist may join with a physician to lease jointly such a building.

Professional tenants, in addition to stipulated fixed rent, may be obligating themselves for additional indefinite, but large, occupancy charges. In extreme cases these charges may exceed the amount of the cash rent called for in a lease.

A dentist agreeing to a cash rent he considers manageable with his practice may discover too late that occupancy costs range from twenty-five to fifty per cent more than anticipated. This will reduce net earnings substantially. In bad years, with professional income off, a dentist may be obliged to pay higher rent. This is not speculation. It has already happened to many commercial and professional tenants. This is because too many tenants look only at dollar rent in lease agreements and fail to read the fine print.

Additional occupancy charges may be either or both of the following:

(1) payment of all property tax increases
(2) payment of part or all building repairs and maintenance

Such additional rent charges may not make rent excessive. Assuming this, a dentist may consider it immaterial whether he pays, say, $100 a month cash rent and an average of $50 a month over the life of his lease for building repairs and taxes or whether, on the other hand, he pays straight rent of $150.

The only defect in this assumption is that no tenant can predict what these charges will be over a five- or ten-year period. Such costs are usually greater than anticipated.

Gambling on Future Costs

Landlords, though familiar with properties, cannot make close estimates of future costs. Some are shrewd enough to pass these obligations on to unsuspecting tenants even less able to estimate future costs. Landlords insisting on such clauses in leases are attempting to transfer some uncertainties of property ownership to tenants. Tenants signing such leases are assuming the risk of property ownership with none of the advantages or prerogatives. A dentist, while adding to insecurities of his practice, is relieving his landlord of comparable insecurities of property ownership.

Consider property taxes. Taxes have been rising for years. There is no reason to expect a reversal of this trend. Tax increases have been due to two factors: (1) increase in tax rates, and (2) increase in tax valuations. Thus assessed values have increased even while properties are aging, even to the point of obsolescence.

This is not to criticize landlords for looking after their own interests. It is underscored only to empha-

CANNY COURTSHIP

A connoisseur knows
The age of a mare
By taking a squint at her teeth;
No trim filly's lips
'Though dewy and fair
Can hide what is lurking beneath!
So girls, if you're older than young
But beguiling,
Wait till the doctor is hung
. . . Before smiling.

Nancy Talbert

size the importance of dentists' reading carefully the fine print and thinking in terms of hidden rental charges. Dentists who, until now, have had suites in large buildings where cash rent is all inclusive are especially apt to ignore such considerations.

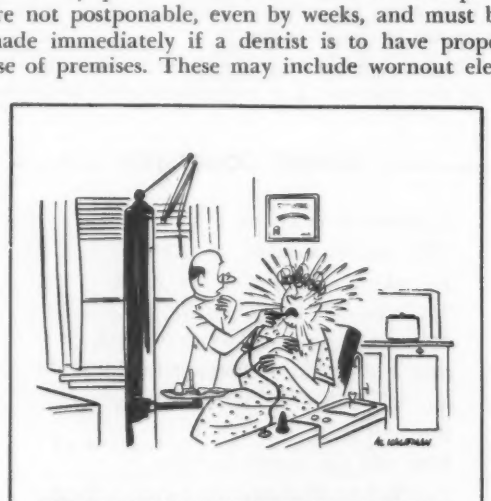
Another point worth considering, if such leases are involved, is this: even while a property is increasing in assessed valuation, and is subject to higher taxes, its value from a professional standpoint may deteriorate. If a property is leased at the peak of its professional value, a dentist may find himself burdened for five or ten years with a high cash rent, plus increasing hidden rent, coincident with its decline in value.

Problems of Repairs

Finally, consider the clause for calling a tenant to make most or all repairs and pay maintenance. Such charges may be negligible or be excessive. One of the principal factors determining the total amount of such expenses is the age of a property. Even if an older building is in fair repair at the time leased, it will cost more to keep in repair than a comparable new building.

Even though obsolescence and repair may be apportioned over a long period, in terms of cumulative costs, this may manifest itself unevenly. Not infrequently, a tenant signs a lease just in time to acquire the obligation to repair certain facilities that have been years in reaching a state of disrepair. This cost, even spread over the first year's occupancy, may double occupancy cost and sharply reduce a dentist's anticipated net earnings.

By the time this repair has been made, other repairs may press for attention. Sometimes repairs are not postponable, even by weeks, and must be made immediately if a dentist is to have proper use of premises. These may include wornout electrical facilities, some designed for lighter loads, and broken-down plumbing and heating equipment.



"OOPS! I NEVER CAN REMEMBER WHICH IS THE AIR SYRINGE!"

Replacements May Be Needed

In many instances, even major repairs will not restore facilities to effective use. In this case, a dentist may be obliged to pay for new replacements as a practical alternative. When he does, such replacements become the property of his landlord if attached in any way to the property. Thus a dentist is actually improving his landlord's property, but he can't take such improvements with him when his lease expires. A dentist can charge off such costs over the life of his lease in his income tax returns, but he will still have an additional out-of-pocket occupancy charge to the extent such costs exceed the income tax saving.

Even such maintenance charges as painting may be excessive. Here again, the older the building the greater the painting cost. Roofing repairs can involve a large outlay over the years.

Estimate First

A dentist should do some careful figuring before voluntarily modernizing a landlord's building. An apparently reasonable rent on an old property with an obsolete front unsuitable for a dental office may be prohibitive, if leasing involves installation of a modern front at a dentist's expense. Such a front is likely to cost more than anticipated. If such a building is under consideration, a dentist should get a close estimate of probable cost before signing a lease. Such cost should be amortized over the life of the lease (including interest on investment) to determine the true rental cost as distinguished from cash rent only.

Actual Rental Costs

For example, a new front costing as little as $3,000, and with interest at 6 per cent of the declining unrecovered cost over a ten-year period, will represent an investment of about $3,900, or $390 a year average over the life of the lease. If cash rent is $1,800 a year, this will make the real occupancy cost about $2,190 a year, or about 22 per cent more than the cash rent.

Even if a dentist has no choice in signing a lease calling for assuming increased taxes and paying maintenance and repair bills, he should compare alternative locations and properties carefully. One location may represent a rent saving while another equally desirable property may involve greater occupancy cost—even though cash rent is identical.

by Maurice J. Teitelbaum, D.D.S.

Since this is September 1st, and September 1st comes but once a year, we have decided to forego our usual dental data and inci-dental items to present a selection from a book of interest to the dentist that will be out this fall. The book is *The Romance of Caverns and Sinuses* by Doctor Felix Phagocyte, Jr. One section deals with how the maxillary sinus was discovered.

"Some people may find it very 'ard to believe that just a few years ago, the maxillary sinus was unknown and nothing more than an 'ole in the 'ead." Thus spoke Sir Joshua Mouthbreather before the Royal College of Surgeons in 1769. And he was right.

During the eighteenth century, teeth firmly embedded in the alveolus were rarely extracted—they were broken off. Occasionally, however, a more ambitious surgeon would tilt the patient's head and at least try to ascertain how much of the tooth was still left in the socket and where it was. Such a man was the gifted Maximillian O'Leary.

Max was born in Devonshire, the son of a cobbler. At seven his social status was advanced considerably – his father became a barber. With this semi-professional background, Max O'Leary grew to manhood and became a dentist.

One day, endeavoring to remove a molar root tip, he noticed that the small piece of tooth disappeared into a dark cavern-like opening just above the upper molar region. "Gadzooks!" he cried, "the spirits have taken the blasted root tip away!" And so saying, he poured the patient a drink—fighting spirits with spirits.

Some time later, the same thing occurred with another patient, only this time a large portion of the tooth disappeared, pulp stones and all. Before the patient died, he had become known far and wide as the man with "rocks in his head."

Visibly shaken by this tragedy, Max O'Leary decided to delve deeply into a more careful study of the bones of the face. He searched for an X-ray machine, but was bitterly disappointed, for in his unbridled enthusiasm he had forgotten that the machine had not been invented yet.

After years of painstaking research, he presented a paper before the Royal College of Surgeons on "Everyone Needs Sinuses Like a Hole in the Head." The report was so well received by the academy members that they immediately named the sinus above the upper molar regions after him--the Max O'Leary Sinus.

Later, during the Irish rebellion, prejudice ran so high in England that even scientific textbooks were purged of any Irish influence and the sinus that bore the name of the great dental surgeon and anatomist was changed to the Maxillary Sinus—a name it has retained to this day, despite the annual protests of the Hibernian Society of Dentists.

Gagging

A dentist upon examining a patient found that his condition would require the services of a specialist and informed him of it.

"What will the specialist charge me?" asked the patient.

"It will probably be twenty-five dollars for the first visit and five dollars thereafter," answered the dentist.

"What do you mean thereafter?"

"Well, it means that the first time you go there it will cost you twenty-five dollars and the next time it will only be five dollars."

The patient was satisfied and the next day went to visit the specialist. When he entered the operating room he asked: "Are you Doctor Brown, the specialist?"

"Yes," answered the dental specialist.

"Well," said the patient, "here I am again!"

A dentist tells us that he once had a patient who was so cross-eyed that every time she cried the tears would roll down her back. That's hard to believe, but if such were the case, we're wondering why she wasn't treated for bacteria.

Thought for the month: When a dentist breaks an appointment with a patient it's usually because he has to. When a patient breaks an appointment with the dentist it's usually because she has two.

Driving a car
In the 80's
Leads to Hades.

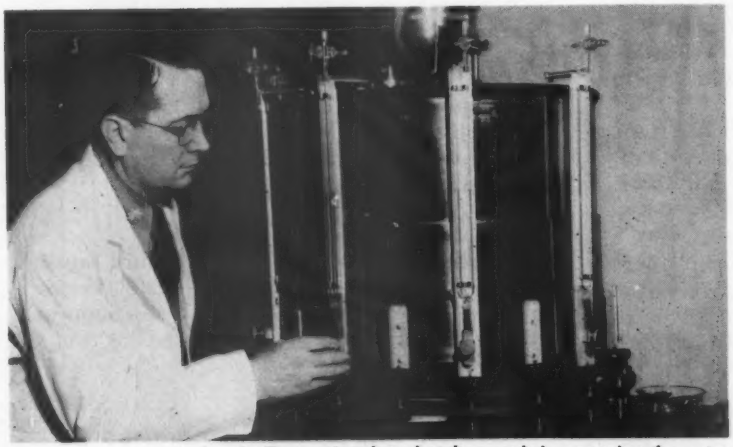
ARMY DENTAL COR 4

Text and [illegible]cated New

Implementation of [illegible]th 3, 191 first commissioning of [illegible]n the Ar contract dental surgeo[illegible] by the [illegible] of the Army on Februa[illegible] very firs[illegible] to obtain dentists for a[illegible]rica, so f show, was the passage o[illegible]ngress of States for conscription [illegible]64. Peak tists on duty for World [illegible]0; for W top figure was 15,292. [illegible]an perio 2,950. The Army Den[illegible]en the r General for its chief [illegible] 1943 a added to make the ra[illegible]eral. D sonnel have pioneered [illegible]tic eyes, chins.

World War I. A view of the typical Army dental field office in World War I. It is a far cry from the dental field chest developed and used in World War II.

Picture above shows a dental officer processing the highly successful plastic eye developed by the Army Dental Corps in its prosthetic laboratories.



A dental officer assigned to dental research is measuring the metabolism of bacteria from oral cavaties by means of a Warburg apparatus.

Major General Walter D. [illegible] Army D[illegible] a professional opinion [illegible] an inspe[illegible]

R 43rd ANNIVERSARY

Text and Pictorial News

ion of th 3, 1911, permitted the
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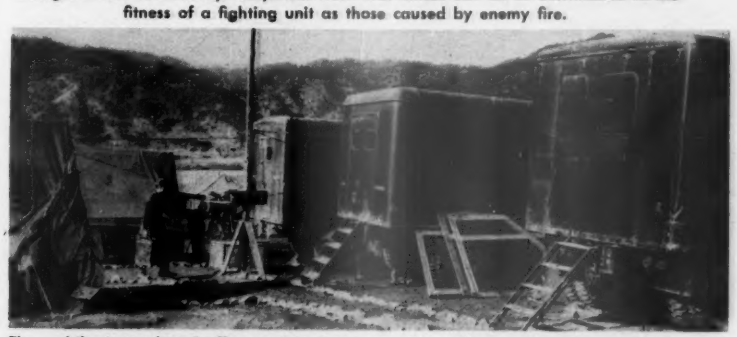
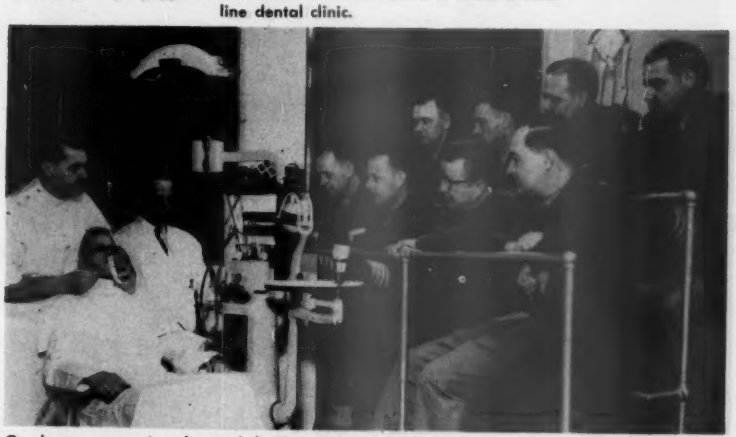
my Dent en the rank of Brigadier
s chief i 1943 a second star was
e the ra eral. Dental Corp per-
ioneered tic eyes, ears, noses and

Walter D. Army Dental Corps, giving
opinion a an inspection tour in the

World War II. The field dental chest being set up near the front lines in World War II. Dental health is an important factor in the maintenance of the fighting strength of the U. S. Army. Days lost from oral illness can be as detrimental to the fitness of a fighting unit as those caused by enemy fire.



The mobile Army dental office used in the Korean War. Here three of the completely equipped vans have been consolidated to make a front-line dental clinic.



Graduate courses in advanced dentistry are available for Army dental officers. Dental officers from other armies—neighboring Canada and other countries—are admitted to the classes held in the Dental Division of the Army Medical Service Graduate School.

International Dentistry:

Dentistry In Colombia

During the sixteenth, seventeenth, and eighteenth centuries the practice of dentistry in almost all the Latin-American countries was limited to the extraction of teeth and was largely in the hands of the barbers. In the city of Santa Fe of Bogota, it was the viceregal physician to whom the most important people came for this type of operation, or, in some cases, the apprentices and herb-doctors instructed by him.

This situation continued through the first half of the nineteenth century, when some American and French dentists visited the country and performed various dental operations, such as fillings with gold and plastic materials and dentures of a metallic base. These dentists received apprentices in their offices. One of them, Joseph Watson Ver Valen, left a very picturesque little work called *Odontotechnics*, published in 1849, for the use of his own apprentices.

In the decade of 1870-1880, the professional success in Bogota of a Colombian dentist who had studied dentistry in the United States awakened much enthusiasm among a number of persons, who followed his example. Among these was Cuillermo Vargas Paredes, a student and later professor at the New York College of Dentistry. When he returned to Colombia, he, in association with several fellow dentists, took part in the creation of a professional association and in the founding of the *Dental Review*. He was also the founder of the Dental College of Bogota in 1888, the first institution organized independently for the teaching of dentistry in Latin America.

This teaching institution functioned without interruption until 1926. Along with the National Dental School, the Dental Institute of Colombia, and the Dental College of Medellin, it represented a step in the development of private education, which terminated in 1932 with the founding of the College of Dentistry of the National University, where, for the first time, it became possible for dental education to take advantage of a close association with the University's College of Medicine and its hospital facilities.

Thanks to the clear vision and the great pioneering spirit of the first director of the dental college, the teaching of dentistry took new directions which placed it in the outstanding position which it holds today in university education. This director, Doctor Miguel Antonio Atuesta, mastered in the United States of America the fundamentals of what he called the "new school". The main objective of Doctor Atuesta was to create a type of instruction in dentistry based on biological science, and to move as a consequence of this idea, toward a new style of professional practice in which scientific principles and ethical consideration would have a dominant role.

The beginning of dental instruction in the universities, initiated in Colombia in 1932 with the establishment of the College of Odontology in Bogota, not only put an end to the defective instruction of small isolated institutions organized as private ventures, but also gave rise to a new orientation which tended to make dentistry a true branch of

Dr. Rafael Torres Pinzon, Professor Emeritus of the National Faculty of Dentistry. Member of the Executive Committee of the Colombian Dental Federation.

Dr. Alvaro Delgado Morales, Dean Professor of La Javeriana Faculty of Dentistry.

Dr. Hernando Neira Florez, President of the Colombian Dental Federation.

Dr. Javier Echavarria Restrepo, Dean of the Dental College of Antioquia. Member of the Executive Committee of the Colombian Dental Federation.

medicine. It also tended to impose upon the practice of dentistry the character of a social responsibility or function. These ideals are pursued today by the new educational centers which, beginning in 1932, have been developing the University of Antioquia, the University of Cadtagena, the Javeriana University, and in 1954, the Free University.

Present State of Dentistry

The dental needs of the Colombian people are tremendous. The number of professional men in practice today is insufficient to fill these needs completely, for there is only one odontologist to every 5000 in the population. However, with the development and progress of the five dental colleges mentioned before—which now have 850 students—and with the anticipated inauguration of a similar center in Cali, as a unit of the University of the Valley, there will be an average of 350 new dentists each year. At this rate, the number of professional men in practice will be doubled within six years.

There is a great shortage in auxiliary personnel, both nurses and dental technicians. Since there are no instructional centers for this training, the public institutions and dentists in private practice must make their own arrangements for training such personnel. Even more urgent is the need for a school for dental hygienists to take care of the campaigns in "sanitary dentistry" and "infant dentistry" which are being planned.

To take care of the oral health of infants among the low-income groups of the population, the Ministry of Public Health has an organization which, through "centers of hygiene," extends its services to children, principally in the smaller centers of population. The Interamerican Public Health Service also has some centers that service infants, and its corresponding dental department is organized as a technical auxiliary for the programs in this area promoted by the Ministry of Public Health. Likewise, under the direction of the S.C.I.S.P., plans are being made for the fluoridation of the water supply of some cities. The water of Girardot and Cundinamarca is now being treated.

Another main front of dental attention is represented by the Odontological Service of the Colombian Institute of Social Security, and organization with which 300,000 workingmen of the most important industries of Bogota, Medellin, and the region of Quindio, Caldas, are affiliated.

The majority of Colombian dentists are organized in a professional association called the Colombian Odontological Federation, made up of the professional organizations of each one of the departments into which the country is divided. This association, whose initial task was focused upon the foundation of the College of Dentistry of the National University in 1932, has been identified with many accomplishments in the profession. In its more recent period, begun in 1947, the Federation has been holding its annual conventions, called "odontologica weeks", in the cities of Bogota, Medellin, Cartagena, Cali, and Bucaramanga.

Javeriana University Dental College.

Last July, in Bogota, the First National Congress of the Odontological Federation of Colombia met. This organization publishes a bimonthly review of a scientific nature, the *Review of the Colombian Odontological Federation.* The three other reviews of the same type published in Colombia are: *Bulletin of Odontology,* founded in 1935 by Doctor Sebastian Carrasquilla, whose most outstanding director has been Doctor Alvaro Delgado, now Dean of the College of Odontology of Javeriana University. *Odontological Themes,* the organ of the Odontological Society of Antioquena, *Dental Herald,* publication of the Odontological Federation of Santander.

Prognosis: Good Future

The functioning of the new dental schools and the establishment in them in 1946 of a new strengthened, extended plan of studies in which the university studies were extended to five years to intensify the instruction in biological studies and the clinical practice of dentistry—will assure in the near future the graduation of enough adequately trained dentists to meet the growing dental needs of the nation.

If we add to this the plans of the Odontological Federation for adding post-graduate courses to the institutions and the sending by our schools, with the aid of the W. K. Kellog Foundation, of professors to take courses in special subjects in the United States of America, it may easily be predicted that Colombian dentistry will, in the immediate future, reach a high scientific and cultural level.

FOR LIVING

Dentist George Albert Selleck — Gourmet Chef

by Joseph George Strack
A three-part series—Part I

Doctor George Albert Selleck is known as the "best barbecue cook in the country."

He is recognized to be one of the greatest amateur chefs in the United States.

He is a noted connoisseur and professional judge of wines.

He owns one of the largest libraries on cooking in existence—more than one thousand volumes.

He recently cooked an entire duck dinner on television one night, creating TV's largest audience of droolers.

He has been the subject of articles in *The Saturday Evening Post* and *This Week* and his culinary art has been praised in *Vogue, Gourmet, Esquire, Sunset, Wine and Food,* and other magazines and newspapers.

Dr. George A. Selleck.

He, one of the world's outstanding amateur gourmet chefs, says solemnly: "We don't eat enough 'garbage.'"

The Man Who Came to Dinner did, and Alexander Woollcott stayed at a Selleck dinner until the next morning—eating his fill of snails, baby octopus, boned lamb with a false tail made of neck bones garnished with lambs' kidneys, mushrooms, asparagus, new potatoes, onions, and hearts of artichokes.

Besides Woollcott, Doctor Selleck's guests have included Gertrude Lawrence, Jack Benny, Supreme Court Justices, generals, statesmen, members of the Wine and Food Society, dental colleagues, students from his alma mater, and just about everybody in the United States who has a sophisticated palate.

Like all artists at the range, he occasionally indulges in the dramatic or the spectacular. He did so for Woollcott's benefit, and his flair for the theatrical was not without success. Woollcott, for example, bluntly announced upon his arrival that he would leave no later than ten o'clock that night, and accordingly instructed his chauffeur to call back for him at that hour. But he was still at the Selleck festive board early the next morning, fascinated by the superb culinary "show" that the dentist-chef had staged for him. Not the least of the dramatic offerings was Woollcott's coffee, which was mixed with blazing brandy and forced through an orange to achieve a taste unique in that beverage.

Another piece of Selleck magic, taken from a thousand-year-old recipe, is a broth, *la petite Marmite Beaunoise.* This he concocts from the wings of a chicken, a marrowbone, and a small piece of whatever meat is being served at dinner.

In fact, Chef Selleck happily cooks feet, legs, combs, and other normally *verboten* parts of chickens, solicits slaughterhouses for spinal cords from the backbones of calves, gratefully accepts from his

butcher the discarded heads and tails of fish, and turns all these odds and ends into delicacies that would stimulate the most jaded of appetites. To those who question such goings on in the kitchen, and mistakenly wonder about the culinary wisdom and ethics of aesthetes and epicureans, Chef Selleck points out by way of explanation that when cowboys are out on the range and want a special treat in the way of food, the chuck-wagon impressario prepares just such a meal by cooking all the so-called uneatables.

"We, like the English, are beef-eaters," he says. "This is a costly dining specialization for us, in terms of health as well as money. Because of our preference for steaks, we waste substantial quantities of other meat, parts of an animal or bird that supposedly are less appetizing or less interesting as food. To mention some of these foods: marrow, gelatin from bones, glandular products, blood." He pauses to emphasize this point: "Such parts contain most of the food values and most of the minerals. So you see, our cowboy friends apparently seem to know more about good, healthful cooking than most of us."

Cooking—Art and Science

Doctor Selleck makes clear that his interest in food is not limited by any epicurean principle of pleasure, but extends to the all-important subject of optimum health. "Most of us know little or nothing about most of the foods we eat," he explains. "As a matter of fact, nobody knows the content of most of the foods we eat. Yet, we do know what we feed our cattle, our pigs, our chickens, and other livestock. We know the mineral content, the protein content, the vitamin content—and we know with scientific precision, exactly what that food will do to maintain and promote the health of the animal or bird that eats it. It is no exaggeration to say that dairy farmers, hog raisers, and chicken farmers know a lot more about feeding their stock than they know about feeding their children or themselves—or the rest of us know about feeding our children or ourselves. As a dentist, I am especially interested in the fascinating study of foods and their direct relationship to robust health. Once we learn the basis for that relationship, we shall have gone far toward solving the health problems of man and beast."

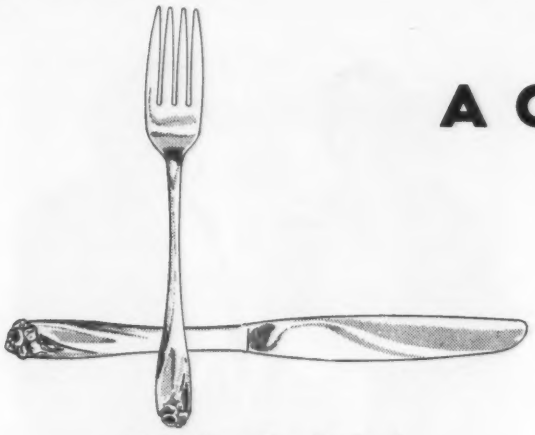
Cooking is not only an art but a science, Doctor Selleck says. "It is a science," he explains, "that begins, not in the kitchen, but on the farm—where food is grown. Food is no better than the soil in which it is grown. For instance, the quality of milk is directly related to the quality of the pasture on which the cow grazes, on the nutritional content of the silage fed to the cow, on the food values of the grain the animal receives."

Dr. and Mrs. Selleck.

Pointing out that although the science of modern nutrition is only at its beginning, he says that its discoveries in the last half century should have helped us to rid ourselves of many superstitions about food and food preparation and taught us to end habits that are costly to our health. "Yet we still throw away the white stalks of chard, which contain the most vitamins," he reminds us. "We boil all the vitamins out of cabbage. And we are notorious for making certain that all the vitamins have been removed from our flour before we use it for baking the 'staff of life'! Nutrition promises to show us, as much as any modern science today, the natural road to good health—how to get to that road and how to stay on it. Of this we can be sure: There is no better way to get the vitamins we need than through good food and good drink."

(For some choice Selleck recipes, see page fourteen.)

NEXT MONTH—PART II



A Gourmet's Own Recipes

***Pissaladiere* (French *pizza*)**

3 tablespoons of olive oil
¾ cup of chopped onion
¼ clove garlic (minced)
1 green pepper
2 No. 2 cans of solid-pack tomatoes
2 8-ounce cans of tomato sauce
1 4-ounce tin of pimento (chopped)
1 teaspoon of salt
⅛ teaspoon of pepper
4 tablespoons of Parmesan (grated)
3 tablespoons of chopped olives
7 fillets of flat anchovies
7 ripe olives

Using a heavy iron skillet, heat the olive oil. Add the onions and garlic, and saute until golden. Cut the pepper in half; remove the core and the seeds; and slice it into strips ¼-inch wide. Then add to the onions and garlic, and cook until soft.

Next, add the tomatoes and tomato sauce. Turning the heat low and covering with an asbestos protector, cook the sauce until it thickens—approximately 2 hours. Stir occasionally with a wooden spoon. (Do not cook it in a double boiler or the mixture will turn brown. The wide bottom of the skillet is important to the success of this sauce.)

When thickened, the sauce should be removed from the heat. Add to it the pimentos, salt and pepper, 3 tablespoons of Parmesan, and the (chopped) olives. This should then be turned into a pastry shell, previously baked in a cake tin. In spoke-of-wheel fashion, arrange the flat fillets over the mixture. Allow a fillet for each portion. Place the cuts of black olives between the "spokes" and put a whole olive in the center. Sprinkle the remainder of the Parmesan (1 tablespoon) on the mixture, then place in a 300 degree oven until it is heated. You will have 10 portions of a superb hors d'oeuvres.

Sauce Provencale

(For Frog Legs Provencale. This sauce can be poured over blanched and poached frog legs, in which event it will not be necessary to soak them in milk overnight. For uses with other dishes, reduce the amount of garlic.)

6 large tomatoes (fresh, or solid-pack No. 2 can)
6 ounces of olive oil
2 small cloves of garlic
2 ounces of (chopped) parsley
1 ounce of sugar
salt and pepper to taste
1 sprig of basil
1 sprig of sweet marjoram (or 1 pinch each of the dry marjoram)

If you use fresh tomatoes, discard the seeds. If canned, force them through a sieve to remove the seeds.

Put the olive oil in a heavy iron frying pan and heat it slightly. Then add the garlic and the parsley, but do not brown. Put in the tomatoes and the other ingredients. Simmer until it is thick—in about 2½ hours.

Frog Legs Lyonnaise

Blanch the frog legs by putting them into a sieve and dipping them in boiling water. *Don't* boil them—not even for a single second!

Let the legs soak in milk overnight or for a comparable period.

When you are ready to prepare the frog legs for eating, saute onion rings in butter until they are golden brown. Remove them from the pan and put them aside.

After patting the frog legs with an absorbent cloth (to remove the moisture), flour them lightly and poach them gently in butter—a maximum of 4 minutes for a medium-sized frog leg.

Then place them in a warm pan and sprinkle them with white wine. Squeeze the juice of one lemon over the pan, and keep it in a warm oven until ready to serve.

Hominy Grits

1 quart of milk
1½ cups of hominy grits
1 teaspoon of salt
⅛ teaspoon of pepper
2 egg yolks
3 tablespoons of Parmesan (grated)
3 tablespoons of butter (or margarine)

Heat the milk to the boiling point and pour it slowly over the hominy grits, stirring thoroughly to make a thick batter. Then add the salt and pepper.

Cook the batter covered over a low heat for 35 minutes, remove, beat in the egg yolks, and add two tablespoons of the Parmesan.

Pour this into a greased baking pan about two inches deep. Chill, unmold it on a cookie sheet, and cut it into 2½x1½-inch squares.

Sprinkle these with the remaining tablespoon of Parmesan, dot them with the butter, and place them in a 250 degree oven for 30 minutes or until the cheese browns and the fat melts. You should have 18 delicious pieces.

Dental Wives:

Homebody or Busybody?

by Kay Lipke

Many a dental husband has viewed with amazement and alarm the transformation of his contented little homebody wife into the president of an organization, an energetic member of two or three committees in other groups, and a highly keyed individual with still other interests outside her home.

She begins her marriage completely absorbed in her husband and their home. When he speaks, she takes as living gospel his remarks on local, national and international matters.

She seems to be utterly satisfied to spend most of her time at home, purring with contentment at doing the household tasks and caring for all the treasured new family furniture, silver, and equipment. She is on tiptoe with eagerness for her husband's return from the office at night, and greets him at the door as if he had been away for months.

Then suddenly—or so it seems to the bewildered husband—the picture changes. She no longer takes his opinions as the last word. She has been attending lectures by experts at her woman's club and is quite apt to interrupt him with a few assorted opinions of her own. She has even been known bluntly to contradict her loving spouse—with temporarily disastrous results.

The telephone rings often in the evening, and no longer are most of the calls for him. Strange female voices brush him off impatiently and ask for his wife. When he calls her from the office during the day, she is either not at home or the line is busy. When he returns at night he very often finds her deep in a telephone conversation, and her greeting is a casual wave of the hand and a cheek obligingly presented for his kiss while she goes right on talking as if he were not there.

Now this can be very disconcerting to a hardworking husband. The premise on which their marriage was founded was that he would look after the office and she would look after the home. Of course, she still does, after a fashion. She has merely enlarged the pattern of her life. If the truth be told, she has been forced to enlarge it.

She is married to a man who is deeply absorbed in his profession. Very often he is on committees of his local dental society or holds office. In short, he talks, thinks, and lives dentistry. After the first glow of marriage dims to everyday habit, she is suddenly very much aware that her life has narrowed down, while her husband's is filled with interesting, stimulating contacts with people, engrossing problems, and other activities which have nothing to do with her. Very often she doesn't have the faintest idea about what he is talking when he discusses dentistry with her.

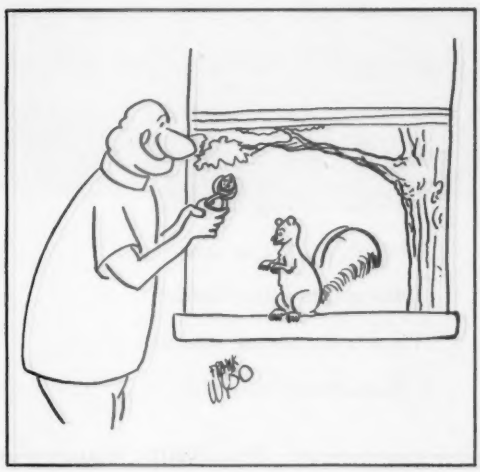
She has at least two choices open to her. In longing to know more about her husband's profession, she may begin working with him as his dental assistant. If she has a flair for quietly fitting into his office procedure, and obeying his instructions without question, she can become a part of his professional as well as his personal life. That can be very satisfying.

She has an alternative, which she may choose without realizing it. A wife finds herself drifting into club activities. Even the most determined homebody can become enmeshed.

"Homebody" or "busybody"—which shall it be? The right answer, probably, would be a little bit of both.

In these troublesome, challenging days when there are community tasks for all of us, the wife who remains at home is a rarity. Such a woman is living only part of a life and using only a fraction of her energy, skills, and abilities. Devoting herself to at least one worthwhile activity would benefit the community and make her a much happier woman.

However, if outside activities intrude on the peace and the intimacy of the home, we women should immediately shed some of our "busybody" projects, no matter how worthwhile and altruistic they may be. If we are nervous and high strung when our dental husbands come home tired at night, we had better take the telephone off the hook, lock the door, and recapture the quiet satisfaction of being just a wife once again.



Dentistry in the Press:

Unloading much-appreciated gifts from Uncle Sam via an American dentist.

Dentistry In Korea

Text by Wide World and photos by U.S. Marine Corps—Wide World

WITH THE FIRST MARINE DIVISION IN KOREA – Some 350 smiling Korean youngsters at the Sam-Ae Orphanage in Seoul recently had an extra Christmas, thanks to a Navy dental officer and the people of two Illinois cities.

Doctor Gordon H. Rovelstad, serving with Headquarters Battalion this division, recently delivered to the institution more than forty large packages containing everything from shoes and toys to school supplies and vitamin pills. He also presented the director, I. H. Shim, with more than 24,000 Whan ($135.).

The Elgin, Illinois, dentist had visited the orphanage before to deliver much-needed supplies, but not in such large quantities. However, that first visit came to the attention of a Far East Associated Press correspondent and a story later appeared in a Chicago paper.

Doctor Rovelstad gives donated funds to Director Shim of Seoul orphanage.

As a result, the Rotary Club of Elgin, which had already contributed much of the initial supplies, and the Waukegan, Illinois, Rotary really went to work, along with other civic-minded groups. Cash, clothes, toys, vitamin pills, school supplies and shoes were donated.

And then there were individual contributions from the States and from Marines in Headquarters Battalion amounting to more than $35.

Doctor Rovelstad said the case should finance the care of forty-five children for a month. It costs about three dollars per month to keep an orphan in food, clothes, and school necessities.

All the busy doctor had to say was: "You should see those youngsters smile."

MEMO TO PATIENTS

Though the dentist's "impressions"
Are not what you think,
And the "case" he refers to
Holds nothing to drink;
Though it's not to strike oil,
He employs his "drill,"
There's no double meaning
Concerning his "bill!"

Ethel Willis Hewitt

DISCRIMINATION

The butcher, the baker, the candlestick-maker
May foregather with impunity;
But the dentist who goes to a party, well knows
He won't enjoy such immunity.
For the miserly pest, in the guise of a guest,
Will unblushingly head, in a trice,
With bicuspid, incisor or molar, a line
In search of free dental advice!

Barbara Becker

20

Ticonium CASES
F ine Grain
I nlay Accuracy
T i-Lectro Polished

The peoples of the state of Colombia are richly endowed with language and manners. Bogata, principal city of Colombia, is more purely Castilian than anywhere else in all of South America; it's people are justly proud of their three hundred and sixteen years of existence.

COLOMBIA

Our cover artist, Mr. Kasper, has re-created the lush vegetation of Colombia through an abstract drawing of the banana tree. Dentistry in Colombia is saluted in this month's "International Dentistry." We praise the advancement and achievements of our [illegible] colleagues.

tic is sent to you with the compliments of your Ticonium Laboratory

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